STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155580	A. BUILDING _____ B. WING _____	03/10/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TIMBERVIEW HEALTH CARE CENTER	2350 TAFT STREET GARY, IN46404

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F0000	This visit was for the Investigation of Complaints IN00086357 and IN00086627. This visit was in conjunction with the post survey revisit (PSR) to Investigation of Complaints IN00084750, IN00084949, and IN00085069 completed on 1/26/11. Complaint IN00086357 - Unsubstantiated due to lack of evidence. Complaint IN00086627 - Substantiated. Federal/State deficiencies related to the allegations are cited at F323. Survey dates: March 8, 9, and 10, 2011 Facility number: 008505 Provider number: 155580 AIM number: 200064830 Survey team: Janelyn Kulik, RN Census bed type: SNF/NF: 133 Total: 133 Census payor type: Medicare: 24 Medicaid: 99 Other: 10 Total: 133	F0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	Sample: 12 This deficiency also reflects State findings cited in accordance with 410 IAC 16.2. Quality review completed 3/17/11 by Jennie Bartelt, RN.			

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F0323 SS=G	Based on record review and interview, the facility failed to ensure two staff assisted a resident to transfer by a mechanical lift. The feficient practice affected 1 of 5 residents reviewed related to falls in a sample of 12. (Resident #C) The resident fell from the lift during transfer, fractured her leg, and was transferred to the hospital for treatment. Findings include: The record for Resident #C was reviewed on 3/8/11 at 12:35 p.m. The resident's diagnoses included, but were not limited to, diabetes mellitus, hypertension, cataracts, and a pressure ulcer. A progress note dated 2/21/11 at 10:33 a.m., indicated fall risk assessment note. A fall risk assessment was completed with a score of 8. This score did not indicated the resident was a high risk for falls. A progress note, dated 2/21/11 at 2:30 p.m., indicated nurses note. The resident was found on the floor in room. The resident was being transferred using Hoyer lift (mechanical lift used to move a resident) and staff stated the Hoyer pad came undone and the resident fell. The resident remained alert and verbally responsive. The resident was unable to	F0323	#1 What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Unable to Correct for resident #C as this occurred in the past and resident #C no longer resides in this facility. #2 How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken. Any resident dependent for transfers requiring a mechanical lift transfer has the potential to be affected by the alleged deficient practice. An audit was completed on resident transfers and a list was composed of residents dependent on a mechanical lift for transfers. An in-service for the CNA's and nurses on falls and transfers will be completed no later than 4/8/11 by the Regional Director of Quality Assurance and the ADON. ADDENDUM: MECHANICAL LIFT TRANSFERS OF DEPENDENT RESIDENTS HAVE BEEN ADDED TO THE CNA KARDEX TO ENSURE TWO STAFF ASSIST DURING TRANSFER. #3 What measures put into place or what systemic changes will be made to ensure that the deficient practice does not recur? An inservice on falls and transfers will be presented to the CNAs and Nurses by the Regional Director of Quality Assurance and by the ADON by April 8, 2011.	04/09/2011

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	move her right arm and right leg. The Hoyer lift was removed from the resident by three staff members, 911 was called and staff remained with the resident. A progress note dated 2/21/11 at 2:30 p.m., indicated fall. The resident fell at 2:30 p.m. Vital signs were temperature 98.8, pulse 95, respirations 24, and blood pressure 167/76. The resident was being transferred by the Hoyer lift to bed by staff and fell. The resident's pupils (eyes) were reactive, neurological check performed due to the resident hitting head on floor. The resident was unable to move right arm and right leg. 911 was called immediately and staff remained with the resident. The resident remained alert and verbally responsive and oriented times three. A change in condition Minimum Data Set Assessment (MDS), dated 1/3/11, indicated the resident was 63 inches tall and 219 pounds she was total dependence, requiring full staff performance every time during entire 7 day period with two plus persons physical assist for transfers. A care plan initiated on 11/15/10, indicated a focus of risk for falls characterized by history of fall/injury, multiple risk factors related to mechanical		ADDENDUM: TRANSFERS WITH TWO STAFF OF DEPENDENT RESIDENTS BY MECHANICAL LIFT HAS BEEN ADED TO THE ORIENTATION OF THE NEWLY HIRED CNA'S. MECHANICAL LIFT TRANSFERS OF DEPENDENT RESIDENTS HAS BEEN ADDED TO THE RESIDENT KARDEX TO ENSURE TWO STAFF ASSIST DURING TRANSFER. #4 How the corrective action will be monitored to ensure the deficient practice will not recur? The DON/Designee will observe 9 staff performing a transfer on totally dependent residents, weekly for one month; monthly for three months, until 100% compliance is met and then quarterly thereafter. ADDENDUM: OBSERVATIONS WILL BE COMPLETED WEEKLY FOR THREE MONTHS AND THEN MONTHLY FOR THREE MONTHS AND QUARTERLY THEREAFTER.	

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	lift for transfers, staff provide ADL (activities of daily living) care, psychotropic medication usage. The interventions included, but were not limited to, transfer and change positions slowly. Mechanical lift for transfers. A hospital form dated 2/22/11, indicated an admission date for 2/21/11 with a chief complaint, "I was dropped on the floor." History of present illness: The resident "presented to the emergency room with a chief complaint of being dropped to the floor with a Hoyer lift. The patient stated that she was moving from the chair to the bed when the Hoyer lift tilted and she fell, resulting in pain and swelling to the right upper extremity and hip." Investigations: "The chest x-ray was negative. The pelvic x-ray revealed an acute fracture of the right femur." Extremities: "The right upper extremity was swollen and tender to palpation and has limited range of motion. The hip is tender to palpation. Straight leg raising test is only about 10 degrees." Impression: The impression included, but was not limited to, fracture of right femur. Plan on admission included, but was not limited to, Orthopedic consultation will be obtained. A reportable incident provided by the			

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	Administrator on 3/9/11 was reviewed on 3/10/11 at 10:30 a.m. The incident dated was 2/21/11 at 2:30 p.m. Staff involved: CNA #1 Description of incident: Resident #C had a fall from mechanical lift. "Type of injury: Admitted to hospital with fracture of right femur. Immediate action taken: assessment of resident, sent to emergency room for evaluation." Resident's physician and family notified and internal investigation completed. CNA #1 was sent home. The mechanical lift and sling was removed from operation pending clearance from vendor. "Preventative measures taken: Direct Care staff in-serviced and return demonstration on use of mechanical lifting devices. Maintenance reviewed all lifting devices on date of event to make sure they were working properly. All lifts were found in proper working order. All slings were examined and found to be in proper condition. Lift and sling used on resident were both proper lift and proper sling. Vendor of lift called to report and came to examine the lift used. Lift examined and found to be in proper order and sling in proper order." "Our follow up investigation included interviews with (CNA #1's name), and we			

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	do not feel this was substantiated abuse or neglect. The CNA did follow procedure and the lift was functioning properly as was the sling." A teachable moment dated 2/24/11, indicated a subject of Hoyer lift transferring a resident from bed to broda chair. CNA #1 "demonstrated the proper use of Hoyer lift while transferring a totally dependent resident from his bed to the broda. Straps were double check by (CNA #1's name), writer and another CNA to ensure resident's safety." A written interview with CNA #1 was provided with the incident report. CNA #1 indicated "was in the room preparing to provide care to (Resident #C's name) around 2:00 p.m. Before placing the (resident's name) in the lift went to go get additional help." CNA #1 "went to (Resident #C's name) room with the lift. The (resident's name) was in the wheelchair with the lift pad under her. Place lift in front of the resident, opened legs" and placed to side, lowered lift as low as it could go. "Lock latches to lift pad to machine, yanked to listen to click and to be in position. Then went to lift her while holding one grab bar of machine." The lift was going then fell. The resident's body slipped out of lift			

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	pad. CNA #1 wrote, on 2/21/11, "I was giving care to (resident's name) I ask QMA #1 for help so I just said I will start to (sic)she come. I hooked the Hoyer pad to the lift. Lifted (resident's name) a little then began to move lift." The "lift pad came apart and she fell. I did not move her I went for help." A written interview provided with the incident from the PCU Unit Manager dated 2/21/11, indicated the Unit Manager was called to the room by QMA #1 that another CNA needed help. The PCU Unit Manager ran to the room and found the resident laying on the floor with other CNA lying by her side. "States resident fell out of the Hoyer lift. Unit manager ran back to the nurses station called 911 et (and) MD (physician)." Unit manager went back to the room and asked the resident what happened. The resident indicated, "She fell off lift states her shoulder hurts and hip. Writer informed staff not to move resident. Resident stated that it was an accident and please don't blame CNA because it wasn't her fault." The Transfer/Position Resident Sling Lift (Maxi Lift) Policy was provided by the Administrator and reviewed on 3/9/11 at			

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	11:10 a.m. The policy indicated, "The lift may be completed by one staff person, however, with the more difficult resident transfer, a second staff person may be required.: The Maxi Lift (mechanical lift) instruction manual was provided by the Administrator and reviewed on 3/9/11 at 11:10 a.m. The manual indicated, can be used by one person. A CNA Assignment Sheet was provided by CNA #2 on 3/10/11 at 10:17 a.m. The sheet indicated Resident #C was total for assist needed and was to use the Hoyer lift. Interview with CNA #2 on 3/10/11 at 10:25 a.m., indicated she had worked for the facility about one year. She indicated Resident #C was a Hoyer lift and a two person transfer. She further indicated she had been oriented by the Assistant Director of Nursing (ADoN) and was trained to use two staff members when using a mechanical lift. Interview with CNA #1 on 3/10/11 at 9:00 a.m., indicated on 2/21/11 at almost 2:00 p.m. she had asked QMA #1 to help her because staff were to use two people during a transfer with the lift. QMA #1			

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	was finishing up with another resident so CNA #1 indicated she went ahead to start with Resident #C. She placed the pad under the resident and heard the clamps snap or click in place and she then started to lift the resident out of her chair. She had moved the resident away from the chair and the clamps came undone and the resident fell. The QMA was not in the room at the time. She further indicated a typical transfer was with two people and she had just started. Interview with CNA #2 on 3/10/11 at 9:22 a.m., indicated anytime a mechanical lift was used other than the sit to stand lift she was always to use two people for the transfer. She indicated she had learned this in her CNA training and during orientation at the facility. Interview with CNA #3 on 3/10/11 at 10:05 a.m., indicated when using a mechanical lift she needs to use someone as spotter. She also indicated there are to be two people when using the mechanical lift. She was taught this in CNA training and in orientation at the facility. Interview with CNA #4 on 3/10/11 at 10:55 a.m., indicated she had just finished transferring the resident with a mechanical lift and her helper had just			

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	walked out of the room. She further indicated when using a mechanical lift she was to use two people for the transfer. She learned this in orientation. Interview with the ADoN on 3/10/11 at 10:00 a.m., indicated she does the staff orientation on transfers. At 10:22 a.m. she indicated they like to the staff to have 2 people for mechanical lift transfers. She further indicated they are taught in orientation to use two people when transferring using a mechanical lift. Interview with the PCU Unit Manager on 3/10/11 at 12:30 p.m., indicated when staff transfer using the hoyer lift they like the staff to use two people but the policy does not indicate they have use two people. She prefers her staff to use two people every since the accident with another resident a couple of months ago. She further indicated that this accident happened prior to the fall of Resident #C from the Hoyer lift. She also indicated that there was only one person on the CNA assignment sheet that she had written was a two person transfer and she really needs to update that sheet. Interview with the Administrator on 3/10/11 at 1:15 p.m., indicated the facility policy states the need for only one person			

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	during transfers. She also indicated staff were told to use two if they can but that would not always be feasible. She further indicated Resident #C could be transferred by one person that two people were for difficult residents which she was not a difficult resident. She indicated difficult would be residents who shake or have behaviors. She then indicated if the CNA had transferred the resident by herself and there had been a need for two person transfer, she would have terminated the CNA. She also indicated that the MDS for a two persons refers to the person and the lift. Interview with the Administrator, Director of Nursing, and the Nurse Consultant on 3/10/11 at 1:55 p.m., indicated the facility followed their policy and if they go above the policy to use two people during a transfer that would be a good thing. This federal tag relates to Complaint IN00086627. This deficiency was cited on 12/28/10. The facility failed to implement a systemic plan of correction to prevent recurrence. 3.1-45(a)(2)			

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